U.S. Department of Labor

Office of Administrative Law Judges
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Date Issued: September 27, 2000

Case Nos: 2000-BLA-315
2000-BLA-316

In the Matter of

ELIGE PENNINGTON (Deceased),
FANNIE PENNINGTON (Widow),

Claimants,

v.

LEECO, INC.,

Employer,

and

ACCORDIA OF LEXINGTON,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

John Hunt Morgan, Esquire
For the claimants

Paul E. Jones, Esquire
For the employer/carrier

BEFORE: DONALD W. MOSSER
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim filed pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972 and the Black Lung Benefits Reform Act of 1977, 30 U.S.C. § 901 et seq. This case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs on January 7, 2000.

In a case involving a living coal miner, benefits are awarded under the Act to a claimant who is totally disabled within the meaning of the Act due to pneumoconiosis arising out of coal mine employment. In a case involving a deceased coal miner, benefits are awarded to survivors of a miner whose death was caused by pneumoconiosis. Pneumoconiosis is defined in the Act as a dust disease of the lungs arising from coal mine employment and the disease is commonly known as black lung.

Following proper notice to all parties, a formal hearing was held in regard to this claim on June 29, 2000 at Corbin, Kentucky. The Director's exhibits were offered in evidence at the hearing pursuant to 20 C.F.R. § 725.456, and the parties were afforded the opportunity to present additional evidence. Counsel also were allowed to submit closing arguments.

The findings of fact and conclusions of law set forth in this decision are based upon my analyses of the entire record and my observation of the demeanor of the witness who testified at the hearing. Each exhibit and argument of the parties, although perhaps not specifically mentioned, has been carefully reviewed and thoughtfully considered. Where the contents of certain medical evidence in the record appear inconsistent with the conclusions reached in this decision, it should be considered that the appraisal of the relative merits of each item of medical evidence has been conducted in conformance with the quality standards of the regulations.

Section numbers hereinafter cited exclusively pertain to Title 20, Code of Federal Regulations. References to DX, CX and EX pertain to the exhibits of the Director, claimant and employer, respectively. The transcript of the hearing is cited as Tr. and by page number.

ISSUES

The following controverted issues remain for decision:

1. whether Elige Pennington had pneumoconiosis as defined by the Act and regulations;

2. whether his pneumoconiosis arose out of coal mine employment;

3. whether the miner was totally disabled;

4. whether his total disability was due to pneumoconiosis; and,

5. whether the miner's death was due to pneumoconiosis.

(DX 63; Tr. 6-7).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The miner, Elige Pennington, was born on December 8, 1930. He married Fannie Henson on July 3, 1965 and she remains his dependent. Mr. Pennington claimed no other dependents on his application for benefits. (DX 1, 7).

Mr. Pennington died on January 25, 1999. The cause of his death was listed in the certificate of death as (1) pneumonia and (2) stroke. Other significant conditions were diabetes mellitus, ischemic heart disease and seizure disorder. Mrs. Pennington has not remarried. (DX 44, 48).

Mr. Pennington filed a claim for black lung benefits on April 24, 1997. The miner was found to be entitled to benefits on August 22, 1997 and again on December 3, 1997. The named employer filed an appeal on December 19, 1997 and requested a hearing before the Office of Administrative Law Judges. Because of the miner's death, the matter was remanded to the district director on February 4, 1999. (DX 1, 15, 16, 18, 35, 42, 48).

Mrs. Pennington filed the survivor's claim involved in this proceeding on February 5, 1999. The application was considered by the Director, Office of Workers' Compensation Programs and benefits were awarded on November 2, 1999. An appeal to the Office of Administrative Law Judges was filed by the coal company on November 16, 1999. (DX 44, 56, 58). Both the miner's claim and the survivor's claim were then forwarded to the Office of Administrative Law Judges. (DX 63).

Coal Mine Employment

Mr. Pennington was a coal miner within the meaning of Section 402(d) of the Act and Section 725.202 of the regulations as he worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. On

his application for benefits, Mr. Pennington alleges 45 years of work in the coal mining industry. The parties agree that he was employed as a miner for at least 33 years. (DX 1, 63). I accept the employer's stipulation and credit the miner with 33 years of coal mine employment. (Tr. 6).

Pneumoconiosis and Related Issues

I. Medical Evidence

The medical evidence of record is as follows:

A. *X-rays*

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
08/08/89 (8/9/89)	DX 52, p. 729	Taylor	Heart slightly enlarged, considerable chronic changes in both lungs consistent with pulmonary emphysema and chronic bronchial disease
04/06/93	DX 24	Broudy/B-reader	0/1; s/t
09/07/94	DX 52, p. 636	Sabbar	Negative
03/22/95	DX 52, p. 529	Antoun	Increased density in right lung likely related to overcrowding of pulmonary vessels and very early infiltrates
04/29/96 (4/30/96)	DX 52, p. 444	Antoun	Emphysematous lungs without evidence of acute cardiopulmonary disease or change since 03/22/95 exam
08/09/96 (08/12/96)	DX 51	Antoun	Interstitial lung thickening without evidence of acute cardiopulmonary disease
10/30/96 (10/31/96)	DX 52, p. 430	Antoun	No significant change since previous exams on 8/09/96 and 4/29/96

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
06/03/97 (06/17/97)	DX 12	Sargent/Board certified radiologist and B-reader[1]	1/2; s/t
06/03/97 (07/25/97)	DX 13	Barrett/Board certified radiologist and B-reader	2/1; q/t
06/03/97 (08/07/97)	DX 14	Baker/B-reader	1/2; t/q
06/03/97 (10/22/97)	DX 28	Scott/Board certified radiologist and B-reader	0/1; t/q
06/03/97 (10/23/97)	DX 28	Wheeler/Board certified radiologist and B-reader	0/1; t/q
06/03/97 (07/27/98)	DX 34	Fino/B-reader	0/1; t/q
06/19/97	DX 51	Antoun	Evidence of pulmonary congestion and edema
06/23/97	DX 51	Antoun	Mild pulmonary congestion and edema with trace bilateral pleural effusions superimposed on chronic interstitial lung disease and emphysematous changes

[1]When evaluating interpretations of miners' chest x-rays, the administrative law judge may assign greater evidentiary weight to readings of physicians with greater qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211 (1985). The Benefits Review Board and the Sixth Circuit Court of Appeals have approved attributing more weight to interpretations of B-readers because of their expertise in this area. *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773 (1984); *Warmus v. Pittsburgh & Midway Coal Mining Co.* 839 F.2d 257, 261, n.4 (6th Cir. 1988). A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). The Benefits Review Board has also ruled that an x-ray interpretation by a physician with dual qualifications of a B-reader and certification by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984).

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
07/04/97 (7/7/97)	DX 51	Antoun	Minimal atelectasis with emphysematous lungs and questionable small pleural effusion
07/26/97	DX 52, p. 241	Antoun	No significant change since 7/04/97 exam; lungs remain emphysematous, but clear
09/03/97 (10/01/97)	DX 24	Broudy/B-reader	0/1; s/t
01/07/99	DX 52, p. 71	Karsh	Chronic mild interstitial disease with mild left basilar atelectasis
01/23/99	DX 52, p. 18	Karsh	Chronic pleural scarring and fibrosis, possible faint developing right upper lobe infiltrate
01/23/99 (04/12/99)	DX 54	Sargent/Board certified radiologist and B-reader	Unreadable film quality

B. *Pulmonary Function Studies*

DATE	EXHIBIT	HEIGHT	AGE	FVC	FEV1	MVV	TRACINGS	EFFORT
06/03/97	DX 8	69"	66	2.86	1.40	52	Yes	Good
[Test results found unacceptable by Dr. Burki on 06/16/97 due to poor effort (DX 8).]								
07/18/97	DX 9	69"	66	2.93	1.19	45	Yes	Good
[Test results found unacceptable by Dr. Burki on 08/07/97 due to poor effort (DX 9).]								
09/30/97	DX 25	69"	66	3.60 (Pre-bronchodilator results)	1.83	41	Yes	----
				3.87 (Post-bronchodilator results)	1.81	46		
[Test results found unacceptable by Dr. Burki on 11/27/97 due to poor effort and equipment did not meet specifications (DX 26)].								

C. *Arterial Blood Gas Studies*

DATE	EXHIBIT	pCO2	PO2	At Rest or after Exercise
09/07/94	DX 52, p. 654	34.0	91.0	At Rest
09/07/94	DX 52, p. 655	37.0	75.0	At Rest
06/03/97	DX 11	33.0	67.5	At Rest
06/19/97	DX 52, p. 301	49.0	81.0	At Rest
06/19/97	DX 52, p. 302	85.0	100.0	At Rest
06/19/97	DX 52, p. 303	55.3	109.6	At Rest
06/19/97	DX 52, p. 304	48.8	80.8	At Rest
06/22/97	DX 52, p. 300	42.0	67.0	At Rest
09/30/97	DX 25	34.9	64.4	At Rest
01/25/99	DX 52, p. 19	52.0	48.5	At Rest

D. *Medical Reports*

The record contains multiple hospital admission records pertaining to Mr. Pennington from October 1991 until the miner's death on January 25, 1999 at Memorial Hospital. (DX 51; DX 52). Dr. Joseph J. James attended the miner during each of these admissions. Following are the findings from these records.

- On October 21 through 23, 1991, the miner was admitted for chest pain. Dr. James diagnosed myocardial infarction, arteriosclerotic heart disease, hypertension and peptic ulcer. (DX 52, pp. 741-804).
- In September 1994, Mr. Pennington was admitted for passing out and a seizure episode. (DX 51). Dr. James diagnosed acute myocardial infarction, convulsions, hypertension, atrophic gastritis without hemorrhage, cardiac arrhythmia, chronic obstructive pulmonary disease, and chronic ischemic heart disease.
- Dr. Leslie Huszar, a Board-certified neurologist, consulted with Dr. James during this admission and diagnosed epileptic seizure. (DX 52, p. 638).
- In January 1995, the miner was admitted for a seizure at his home. (DX 52, pp. 586-602). Dr. James diagnosed epileptic seizures.

- On March 22, 1995, the miner was admitted for gastro-intestinal bleeding and underwent an esphagogasroduodenoscopy. (DX 51).

- Mr. Pennington was admitted from February 25, 1996 until March 3, 1996 for cerebrovascular accident. (DX 52, p. 460). Drs. James and Steve Spady attended the miner and made a primary diagnosis of lacunar stroke. They also diagnosed mild left hemiparesis, seizure disorder, chronic obstructive pulmonary disease, acute bronchitis, hypertension, ischemic heart disease and glucose intolerance.

- In October 1996, Dr. James treated Mr. Pennington for obstructive jaundice secondary to pneumopaludism during an admission from October 31, 1996 until November 8, 1996. (DX 51; DX 52, p. 352). He noted a history of smoking one and one-half packs of cigarettes a day for many years before quitting in 1991 and a history of working as a coal miner for many years beginning at the age of 15. Dr. James also diagnosed cholangitis, seizure disorder, coronary artery disorder, chronic obstructive pulmonary disease, coal workers' pneumoconiosis, old myocardial infarction, hyperglycemia, hematuria, hypertension, peptic ulcer disease and insulin dependent diabetes mellitus out of control.

- In June 1997, Dr. James treated the miner for a myocardial infarction. (DX 51).

- On September 17, 1998 until September 22, 1998, the miner was hospitalized for acute bronchitis with chronic obstructive pulmonary disease exacerbation.

- The miner was later admitted on December 1, 1998 and released on December 7, 1998 for acute cholecystitis. (DX 51).

- Dr. James attended the miner again for an admission on January 7 through 12, 1999 for gastroenteritis, and also diagnosed urinary tract infection, dehydration, hypertension, seizure disorder, chronic obstructive pulmonary disease, ischemic heart disease and old myocardial infarction. (DX 51).

- The final admission was from January 23, 1999 until the miner's death on January 25, 1999, in which Dr. James attended the miner for severe shortness of breath, congestion and coughing. Dr. James diag-

> nosed pneumonitis and secondary diagnoses of ischemic heart disease, stroke, liver dysfunction, chronic obstructive pulmonary disease, diabetes mellitus, hypertension and seizure disorder.

Dr. Bruce C. Broudy examined Mr. Pennington on April 6, 1993 and again on September 30, 1997. (DX 24). Dr. Broudy noted a medical history, a smoking history of 1 to 1 1/2 packages of cigarettes per day for 30 to 35 years before quitting 6 years ago, and a history of working 44 years in the coal mines, lastly employed on the beltline and head drive. Based on the results of a physical examination, chest x-ray, blood gas study and pulmonary function study, he diagnosed moderately severe to severe chronic obstructive airways disease, cerebral vascular disease and history of coronary artery disease. Dr. Broudy stated that the miner does not have coal workers' pneumoconiosis. He opined that the miner is disabled due to his cardiovascular disease and cigarette smoking and is unable to perform the work of an underground coal miner. Dr. Broudy concluded that Mr. Pennington does not have any significant pulmonary disease or respiratory impairment which has arisen from his coal mine employment or exposure to coal dust. Dr. Broudy is Board-certified in internal medicine and pulmonary medicine.

This physician was deposed on December 23, 1997. (DX 28). After Dr. Broudy recited his medical credentials and read into the deposition his medical report of September 30, 1997, he reaffirmed the medical opinions and conclusions of his earlier September 30, 1997 report.

The record contains the hospital records of an admission at the University of Kentucky Hospital from March 22-25, 1995 for gastro-intestinal bleeding. (DX 33). Dr. Paul J. Nicholls attended the miner for an active bleeding gastric ulcer. He noted 35 pack years of smoking. Dr. Nicholls diagnosed chronic obstructive pulmonary disease, coronary artery disease, cirrhosis and black lung disease.

Dr. Glen Baker examined Mr. Pennington on June 3, 1997. (DX 10). He conducted a physical examination, as well as a chest x-ray, a pulmonary function study, and a blood gas study. Dr. Baker considered a history of smoking one pack of cigarettes a day for an unspecified period of time and 40 years of coal mine employment, mostly recently running a head drive. Dr. Baker diagnosed coal workers' pneumoconiosis due to coal dust exposure and chronic obstructive pulmonary disease, hypoxemia, chronic bronchitis, all of which he attributes to coal dust exposure and cigarette smoking. He also diagnosed ischemic heart disease by history and caused by arteriosclerotic heart disease. Dr. Baker opined that the

miner has severe pulmonary impairment caused by coal dust exposure, coal workers' pneumoconiosis and cigarette smoking. He concluded that the miner does not retain the respiratory capacity to perform the work of a coal miner or other comparable work in a dust-free environment.

The medical records were reviewed by Dr. Ben V. Branscomb on July 21, 1998. (DX 34). He noted a total of 34 years of coal mine employment, 10 years above ground and the rest underground. Dr. Branscomb also considered a medical history, a history of smoking 1 to 1-1/2 packs of cigarettes daily for 35 years, and the medical reports of Drs. Broudy, Baker and Nicholls, 6 chest x-rays, and 2 pulmonary function studies. He diagnosed severe coronary artery disease with myocardial infarctions and repeated paralyzing strokes, chronic obstructive pulmonary disease and severe cirrhosis of the liver. He found insufficient evidence to diagnose coal workers' pneumoconiosis. Dr. Branscomb found the miner was disabled due to moderately severe obstructive lung disease caused by heavy cigarette smoking in addition to the breathing effects related to his strokes. He found no discern- able evidence that his disability is to any degree the consequence of coal dust exposure or coal workers' pneumoconiosis.

Dr. Gregory J. Fino, who is Board-certified in internal medicine and pulmonary disease, reviewed the miner's medical records on July 27, 1998. (DX 34). Dr. Fino considered 44 years of coal mine employment, lastly on the beltline and a history of smoking 1-1/2 packages of cigarettes per day for 35 years before quitting in 1991. He also reviewed a medical history, 9 chest x-rays, and 2 pulmonary function studies. Dr. Fino found insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis. In his opinion, the miner does not suffer from an occupationally acquired pulmonary condition. He found moderate respiratory impairment present due to cigarette smoking and concluded that Mr. Pennington would be as disabled as if he had never stepped foot in the mines.

This physician reviewed the medical records for a second time on June 6, 2000. (EX 2). Dr. Fino reviewed additional medical evidence which included various hospital admissions from 1989 until Mr. Pennington's death on January 25, 1999, the death certificate, additional chest x-rays and blood gas studies. He found no evidence of coal workers' pneumoconiosis or any other coal dust related pulmonary condition. He did note that there is evidence of numerous other medical problems including strokes, heart attacks, malnutrition and seizures, none of which is related to his coal mine employment. Dr. Fino attributes the miner's pulmonary impairment to smoking. He stated that the miner's primary cause of death was pneumo-

nia due to a stroke and which has no causal relation to coal mine dust inhalation. In summary, Dr. Fino stated that coal dust inhalation did not cause, contribute to, or hasten the miner's death. The miner would have died as and when he did had he never stepped foot in the coal mines, according to this physician.

Dr. Keith W. Chandler, who is Board-certified in internal medicine and pulmonary disease, reviewed the medical evidence to date on January 25, 1999 and again on December 10, 1999. (DX 41; EX 1). He reviewed the medical reports of Drs. Baker and Broudy, the chest x-rays and pulmonary function studies. He noted 44 years of coal mine employment, a history of smoking 1 to 1 1/2 packages of cigarettes per day for 30 to 35 years and a medical history. Based on his review of the medical records, Dr. Chandler diagnosed coronary artery disease with multiple cerebro- vascular accidents leaving the miner with neuromuscular impairment, a seizure disorder, peptic ulcer disease, systemic hypertension, non-insulin requiring diabetes mellitus, and chronic obstructive pulmonary disease. He found no evidence of coal workers' pneumoconiosis and no restrictive impairment. Dr. Chandler found the miner does not retain the respiratory capacity to perform the work of an underground coal miner, but in no way did he attribute this impairment to coal workers' pneumoconiosis in whole or in part. The origin of Mr. Pennington's impairment, Dr. Chandler concluded, is the miner's prolonged and heavy cigarette smoking.

Dr. Chandler subsequently reviewed the medical evidence on December 10, 1999. (EX 1). The physician reviewed various hospital admissions from 1991 until the miner's death, the death certificate, and a chest x-ray. From his review of the medical records, Dr. Chandler concluded that the miner had a vast array of diseases which affected virtually all of his organ systems. He stated that his prior medical opinions of January 25, 1999 remain unchanged. In his opinion, there is no evidence of coal workers' pneumoconiosis and Mr. Pennington did not have any impairment which arose from coal mine employment. Dr. Chandler opined that the miner's death was in no way related to coal workers' pneumoconiosis nor was it in any way hastened by coal workers' pneumoconiosis. He found death was a result of inanition chiefly attributable to the miner's end-stage liver disease.

Mr. Pennington died on January 25, 1999, and Dr. Joseph J. James signed the death certificate. (DX 48). He listed the causes of death as pneumonia and stroke. He listed ischemic heart disease, diabetes mellitus and seizure disorder as other significant conditions contributing to death but not resulting in the underlying causes of death.

II. Discussion

Miner's Claim

In order to be entitled to benefits, the claimants must establish that the miner had pneumoconiosis, that he was totally disabled as a result of that disease and that the pneumoconiosis arose out of coal mine employment. Mr. Pennington filed the claim on which this appeal is based on April 24, 1997. (DX 1). The claim must, therefore, be considered under the amendments to Part 718 of the regulations, which are effective for claims filed after March 31, 1980.

Section 718.202 provides the methods by which a claimant may establish the existence of pneumoconiosis under this part of the regulations. Under Section 718.202(a)(1), a chest x-ray conducted and classified in accordance with Section 718.102 may form the basis for a finding of the existence of pneumoconiosis.

The record contains 21 readings of 15 different x-rays. There are three positive readings for pneumoconiosis and 18 readings that cannot be construed as diagnosing pneumoconiosis. The first seven x-rays, taken between August 8, 1989 and October 30, 1996, were not read as positive for pneumoconiosis.

The June 3, 1997 x-ray was found positive three times and negative three times. Drs. Sargent and Barrett, who are both B-readers and Board-certified radiologists, found the film positive, as did Dr. Baker, a B-reader. On the other hand, Drs. Scott and Wheeler, who are dually certified readers, and Dr. Fino, a B-reader, felt the film was negative for pneumoconiosis. Because the readings are equally divided, the preponderance of the evidence does not prove this x-ray to be positive.

The six final x-rays, taken between June 23, 1997 and January 23, 1999, were found either negative or unreadable. Based on the most recent x-rays of record, the readings of the majority of best qualified interpreters, and the overall weight of the evidence, I find that the evidence does not tend to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(1).

A biopsy conducted and reported in compliance with Section 718.106 may also be the basis for a finding of the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). However, there is no biopsy evidence in the record to consider.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305 or 718.306 are applicable. Since there is no x-ray evidence of complicated pneumoconiosis in the record, Section 718.304 does not apply. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant since it is to be used in connection with the claims of miners who died on or before March 1, 1978.

Section 718.202(a)(4) provides that a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based on objective medical evidence, and shall be supported by a reasoned medical opinion.

This record contains the opinions of five physicians and hospital records which must be considered under this section of the regulations. Drs. James, Nicholls, and Baker diagnosed pneumoconiosis, while Drs. Broudy, Branscomb, Fino, and Chandler did not.

The opinions of Drs. Broudy, Branscomb, Fino, and Chandler are well documented and reasoned. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). For this reason, I find all of their opinions probative. Drs. Broudy, Fino, and Chandler are also Board- certified in both internal medicine and pulmonary disease, and I defer to their superior qualifications in the field of pulmonary diseases. *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985). Dr. Branscomb is only Board-certified in internal medicine. His credentials in the field of pulmonary medicine, however, are beyond reproach. I also place great weight on Dr. Broudy's opinion because he had the opportunity to examine Mr. Pennington in 1993 and 1997, thus providing him with a four-year span over which to observe any changes in the miner's physical condition. I place great weight on the opinions of Drs. Branscomb, Fino, and Chandler because they each reviewed the medical evidence of record, thus providing them with a broad base of information from which to draw their conclusions.

I place weight on Dr. James' opinion because he was the miner's attending physician beginning in October 1991, and thus was probably more familiar with his health condition. *Schaaf v. Matthews*, 574 F.2d 157, 160 (3d Cir. 1978); *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993). I note, however, that Dr. James did not make the diagnosis of pneumoconiosis until the October-November 1996 hospitalization, yet no x-ray taken around that time would have supported

the diagnosis. The diagnosis seems to be based on a history provided by the miner himself, as opposed to one adduced by Dr. James based on medical evidence. Moreover, Dr. James appeared to have only a nebulous idea of Mr. Pennington's coal mine employment history. Consequently, I do not place great weight on his opinion.

I place little weight on Dr. Nicholls's assessment of pneumoconiosis because his primary objective was to treat the miner's active bleeding gastric ulcer. Although he noted Mr. Pennington's smoking history, he did not chronicle his coal mine employment history, thus rendering his opinion less than well reasoned and documented. *Minton v. Director, OWCP*, 6 BLR 1-670 (1983); *see Perry*, 9 BLR 1-1.

Dr. Baker's opinion merits somewhat less weight because the smoking history on which he relied is not sufficiently detailed. Because Mr. Pennington's smoking history was extensive, I find this lack of data significant enough to detract from Dr. Baker's finding. *Stark v. Director, OWCP*, 9 BLR 1-36 (1986).

For the reasons stated above, I find that the medical opinion evidence does not tend to establish the existence of pneumoconiosis pursuant to Section 718.202(a)(4). Upon consideration of all the evidence under Section 718.202, I also conclude that the claimants have failed to establish the existence of pneumoconiosis. *See Island Creek Coal Co. v. Compton*, ___ F.3d ___, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3rd Cir. 1997).

The claimants must also establish that the miner's pneumoconiosis was caused at least in part by his coal mine employment. In this case, however, that relationship may be presumed because it has been established that the claimant worked at least ten years as a coal miner. 20 C.F.R. § 718.204(b)(2). Moreover, the weight of the medical evidence fails to establish any cause for the miner's pneumoconiosis, if he had it, other than coal mine employment. Thus, the presumption is not rebutted.

After the claimant has established pneumoconiosis arising from coal mine employment, he must still establish that he has been totally disabled by the disease. A claimant is considered totally disabled when he is no longer able to perform his usual coal mine work. 20 C.F.R. § 718.204(b)(2). Section 718.204 provides several criteria for determining that a claimant is totally disabled.

Subsection (c)(1) of Section 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1 values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC values or MVV values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove a totally disabling respiratory impairment under this subsection of the regulations.

There are three pulmonary function studies of record. All produced qualifying[2] values but each test was also invalidated by Dr. Burki, who is Board-certified in internal medicine and pulmonary disease. He found the miner's effort to be poor on each study. Because of the absence of a valid, qualifying study, I find that the claimant has not established total disability pursuant to Section 718.204(c)(1).

Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the claimant's lung alveoli to his blood. 20 C.F.R. § 718.204(c)(2) and Appendix C.

There are ten blood gas studies of record, and four yielded qualifying values. The qualifying studies include the two most recent studies of record. Relying on the most recent evidence of record, I conclude that the miner has established total disability pursuant to Section 718.204(c)(2).

A miner shall be considered totally disabled under Section 718.204(c)(3) where he suffers from pneumoconiosis and has been shown by medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure. There is no such evidence in this case.

Where total disability cannot be established under subparagraphs (c)(1), (c)(2) or (c)(3), Section 718.204(c)(4) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques concludes that a miner's respiratory or pulmonary

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[2] A "qualifying" pulmonary function study or arterial blood gas study yields values which are equal to or less than the applicable table values, *i.e.*, Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(c)(1) and (c)(2). A"non-qualifying" test produces results which exceed the requisite table values.

condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

Drs. James and Nichols did not provide opinions regarding Mr. Pennington's respiratory disability. Dr. Baker felt the miner was totally disabled and suffered severe pulmonary impairment due to pneumoconiosis and cigarette smoking. Dr. Broudy found Mr. Pennington totally disabled due to his cardiovascular disease and cigarette smoking. He found no significant impairment arising from his coal mine employment. Dr. Branscomb opined that the miner was disabled due to chronic obstructive pulmonary disease caused by cigarette smoking and stroke. He found no disability due to pneumoconiosis. Dr. Fino felt Mr. Pennington was moderately impaired due to his cigarette smoking, not pneumoconiosis. Dr. Chandler found no restrictive impairment. However, he did assert that the miner was totally disabled due to smoking, but not pneumoconiosis.

Consideration of all the medical opinions leads to the finding that Mr. Pennington was totally disabled from a respiratory standpoint pursuant to Section 718.204(c)(4). This is further supported by the blood gas study evidence. Thus, the weight of the evidence supports a finding of total respiratory disability on the part of Mr. Pennington.

The miner must also establish that his disability arose out of coal mine employment. The Sixth Judicial Circuit, under whose jurisdiction this claim arises, requires a finding under Section 718.204(c)(4) that the claimant's total disability is due not just to a respiratory or pulmonary impairment, but to pneumoconiosis. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 12 BLR 2-254 (6th Cir. 1989). In satisfying that standard, the Sixth Circuit has held that a miner need only affirmatively establish that the totally disabling respiratory impairment is due "at least in part" to pneumoconiosis. *Adams v. Director, OWCP* 886 F.2d 818, 13 BLR 2-52 (6th Cir. 1989).

None of the hospital records provides an opinion on the etiology of the miner's disability. As noted above, Dr. Baker attributed Mr. Pennington's disability to smoking and pneumoconiosis. Drs. Broudy, Branscomb, Fino, and Chandler opined that the disability was due to cigarette smoking and not pneumoconiosis.

The opinions of Drs. Broudy, Branscomb, Fino, and Chandler merit greater weight because they are supported by the miner's extensive smoking history, as well as his remarkable medical history that included heart disease and strokes – conditions which affect the respiratory system. Drs. Branscomb, Fino, and Chandler reviewed all the medical evi-

dence of record in reaching their conclusions, and I find their extensive reviews add to the probity of their opinions. Dr. Broudy's opinion is supported by two separate physical examinations over a four-year period. Adding further support to the opinions of these physicians are the hospital records, which reveal hypertension, a heart attack, epilepsy and strokes.

On the other hand, Dr. Baker's opinion is based in part on a pulmonary function study, which was found on review to be questionable, an unspecified smoking history, and a positive x-ray. These factors detract from the credibility of his conclusions. Consequently, I find, based on the weight of the more reasoned medical reports, that Mr. Pennington has failed to establish that he is totally disabled due to pneumoconiosis. Thus, he is not entitled to benefits and his claim must be denied.

Widow's Claim

It must also be determined whether the pneumoconiosis which Mr. Pennington suffered was caused at least in part by his coal mine employment. In this case, however, that relationship may be presumed because it has been established that the claimant worked at least ten years as a coal miner. 20 C.F.R. § 718.203(b). Moreover, the weight of the medical evidence fails to establish any cause for the miner's pneumoconiosis other than coal mine employment. Thus, the presumption is not rebutted.

Mrs. Pennington must also prove that pneumoconiosis caused the miner's death. Section 718.205(c) provides that with respect to survivors' claims filed after January 1, 1982, death will be considered due to pneumoconiosis if any one of the following criteria are met:

(1) where competent medical evidence establishes the miner's death was due to pneumoconiosis; or,

(2) where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis; or,

(3) where the presumption set forth in Section 718.304 is applicable.

Initially, I note that the presumption at Section 718.304 is not applicable to this claim because there is no evidence of complicated pneumoconiosis. Therefore, death due to pneumoconiosis is not established by this method. 20 C.F.R. § 718.205 (c)(3).

Section 718.205(c)(2) presents a liberal standard for proving "death due to pneumoconiosis." Moreover, some of the circuits which have considered that standard have accepted the interpretation of the Director "that the words 'substantially contributing cause or factor leading to the miner's death' . . . means anything that has 'an actual or real share in producing an effect' and that any condition which hastens death fits this description." *Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1004 (3d Cir. 1989); *see also Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992); *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992).

The three opinions impacting upon this issue come from Drs. James, Fino, and Chandler. Dr. James, who signed the death certificate, listed the cause of death as pneumonia and stroke. He provided ischemic heart disease, diabetes mellitus, and seizure disorder as other conditions contributing to death but not resulting in the underlying cause of death. Dr. Fino averred that death was due to pneumonia due to a stroke. He found no connection between coal mine dust inhalation and the miner's death. Similarly, Dr. Chandler opined that Mr. Pennington's death was in no way related to coal workers' pneumoconiosis. He felt the miner's death was the result of inanition primarily attributable to end-stage liver disease.

I place weight on Dr. James's opinion because he began attending Mr. Pennington in the hospital in 1991 and attended him during his final hospital stay, rendering him more familiar with the miner's medical condition. *Schaaf v. Matthews*, 574 F.2d 157, 160 (3d Cir. 1978). I also place greater weight on the opinions of Drs. Fino and Chandler because of their credentials and because their opinions are based on a review of the entire medical record. *Wetzel v. Director, OWCP*, 8 BLR 1-139 (1985). For these reasons, and because there is no evidence that pneumoconiosis in any way hastened Mr. Pennington's death, I find that Mrs. Pennington has failed to establish that the miner's death was due to, substantially contributed by, or in any way hastened by pneumoconiosis. Thus, her claim must be denied.

Attorney's Fee

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any attorney's fee to the claimant for legal services rendered in pursuit of benefits.

ORDER

The claims of Elige Pennington (Deceased) and Fannie Pennington (Widow) for benefits under the Act are denied.

_____
DONALD W. MOSSER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Workers' Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601. See 20 C.F.R. §§ 725.478 and 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.